PERSPECTIVE

Competitive Markets For Individual Health Insurance

With some sensible policy changes, the individual health insurance market has the potential to serve a growing customer base.

by Scott Harrington and Tom Miller

ABSTRACT: A more dynamic individual insurance market could match benefits with individual preferences, provide more portable and permanent coverage, and stimulate consumer-focused service. Necessary reforms, such as tax parity and targeted assistance to high-risk pools, would enable individual coverage to expand efficiently. In contrast, requirements for guaranteed issue and community rating drive low-risk persons out of voluntary individual markets and raise overall premiums. Guaranteed renewability and switching costs would stabilize individual-market risk pools. As the individual market becomes more representative of the overall population, insurers' perceived needs to underwrite and market selectively will lessen, making administrative loading factors less significant.

THE SMALL MARKET SHARE for individual health insurance reflects in part the long-standing tax subsidy that favors employment-based group insurance. The existing safety net for the uninsured further reduces incentives to buy individual coverage. Many argue that the supply of individual coverage will remain thin in the face of high administrative-expense ratios and pervasive underwriting/risk selection. However, a closer look at evidence from other types of insurance suggests that sensible policy changes would enable individual coverage to expand efficiently and provide a viable alternative to group coverage for millions more Americans.

Competition in most insurance markets creates relentless pressure for accurate pricing and risk classification. Conventional theory suggests that risk classification using low-cost information provides appropriate incentives for policyholders to manage their risk of loss.[1]

On the other hand, competitive risk classification contributes to two problems that may sometimes be more severe in the individual coverage market. First, some insurance buyers will have high risk of loss ex ante, which may make competitively priced coverage unaffordable for them. Moreover, current policies that favor employer coverage (such as the tax exclusion and the ERISA preemption of state regulation of self-insured plans) augment its natural advantages of relatively lower marketing and administrative costs (scale economies, payroll deduction, noncustomized group purchasing, bargaining leverage, and so on) and make the current individual market act in many respects more like a residual pool of people unable to access an employer group plan. Insurers necessarily are more skeptical about insuring these persons at standard rates.

Second, policyholders may face some risk that a deterioration in their health will cause

Scott Harrington is W. Frank Hipp Professor of Insurance at the Moore School of Business, University of South Carolina. Tom Miller is director of health policy studies at the Cato Institute in Washington, D.C.

future coverage to become much more costly or unavailable. Because individual insurance plans arguably serve the least stable risk pools, they may provide less protection against such health risk redefinition.[2] However, relatively few people are chronically uninsurable because of health status.[3] Suitably designed high-risk pools can readily provide coverage to those buyers at subsidized rates.[4] The bigger problem is that many low-risk individual-market buyers may face rates that are higher than they are willing to pay. Indeed, regulatory efforts to limit the permissible set of standardized individual insurance policies and to block insurers' ability to use selection mechanisms ultimately have failed even in making individual insurance more accessible to high-risk customers, because they drive low-risk people out of a thinning, voluntary individual market and raise overall premiums.[5]

Moreover, the problem of risk reclassification ("durational effects") that has achieved notoriety in the small-group market is of much less concern for individual coverage. Any existing problems are more likely aggravated by the individual market's small size, its disproportionate number of high-risk persons compared with the group market, and its relative lack of persistent purchasers.

Response To Insurance-Market Concerns

The sensible responses to the above concerns are to (1) change tax rules for individual coverage, (2) facilitate the formation of more stable purchasing arrangements to help achieve scale economies and reduce expense ratios, and (3) if necessary, provide targeted assistance to high-risk purchasers instead of attempting to impose cross-subsidies through counterproductive regulation.

■ **Change the tax rules.** Much has been written about the need for tax parity, instead of a tax penalty, for purchasers of individual insurance.[6] Recent proposals have tended to focus too narrowly on targeted, refundable tax credits for low-income workers who lack access to employer coverage.[7] Broader access to more comparable tax treatment for all health insurance consumers, regardless of where or how they purchase insurance, is needed to provide a deeper, more diversified pool of potential customers and move the individual market beyond a narrow niche role.

■ **Facilitate more stable purchasing arrangements.** If sensible reforms increase the demand for individual coverage, guaranteed renewability (at rates that reflect the initial risk-based underwriting of new entrants, combined with the subsequent experience of the policyholder's class) should ensure stable supply for most policyholders. Roughly three-fourths of individual policies were already guaranteed renewable before the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and before most states mandated guaranteed renewability.[8] It is the norm in the enormous individual life insurance market, as well as in the market for individual disability income coverage. Individual health insurance is often more akin to those coverages than to small-group health insurance.

Some fear that insurers will skim healthy policyholders from rating groups if rates reflect the experience of policyholders whose health has declined. Theoretical analyses have emphasized mechanisms that might prevent this problem, such as front-end loading of premiums or severance payments conditional on health status.[9] In any case, switching insurers to get lower rates is costly to individual policyholders, and comparatively more so than for small groups. As long as relatively few policyholders experience material reductions in health status, switching costs are likely to swamp the savings that a healthy policyholder might achieve by changing insurers, thus encouraging stable risk pools with guaranteed renewable rates. Switching costs are relatively lower even for small groups, because they are spread over more people. Moreover, the probability is greater that at least one member of a small group might develop a condition that will require expensive treatment. Front-end underwriting and policy issue costs are higher for new coverage than for renewal coverage. Because insurers generally seek to recover those costs over the duration of the contrac-

tual relationship, policyholders' costs will be lower when they stick with one insurer.

The implicit "lock-in" associated with switching costs will not produce widespread opportunistic behavior by insurers, given presumed reputation concerns and their desire for high renewal rates to spread up-front costs, especially if other policy changes increase demand and the number of competitors. Insurance contracts that are guaranteed renewable and, implicitly, more long term, will give individual buyers incentives to shop more diligently for assurances of quality. Abundant evidence for other types of coverage, such as individual auto insurance (including the nonstandard market for high-risk drivers) suggests that many reputable insurers would enter the market if demand rose dramatically—unless they were dissuaded by fear of regulation or other potentially expropriative government policies, such as a single-payer system.

■ **Assist high-risk purchasers.** Another necessary element in both deepening and stabilizing the risk pool for individual insurance involves spreading the cost burden of subsidizing high-risk consumers more widely through more generous general revenue support of high-risk pools and "carriers of last resort." Moving away from regulatory controls that try to limit risk segmentation through rate compression and limits on benefits will attract more low-risk buyers and competing insurers to the individual market and keep average premiums lower. When insurers are kept from pricing predicted risk appropriately and matching their policy configurations to market demands, they resort to higher uniform prices, risk avoidance, and, ultimately, market exit. We should separate support for societal objectives of income redistribution and protection against prohibitively expensive, but predictable, health risks from the competitive operations of commercial insurance markets. Adequately funded high-risk pools can provide affordable coverage for persons with serious, chronic conditions or with more acute illnesses of shorter duration more effectively and at lower costs than do requirements for guaranteed issue and community rating.[10]

Offering Some New Alternatives

If one envisions a near-term future marketplace reinvigorated by individual tax credits, employer-sponsored defined-contribution health benefit plans, premium support–style Medicare reform, multitier worker-empowerment answers to the managed care backlash, and enhanced information technologies that facilitate consumer-driven health care, new alternatives to one-size-fits-all employer plans and distorted individual-market options can serve a growing customer base. The payoffs from a dynamic individual insurance market could include more customized matching of insurance benefits to one's individual values and preferences, insurance that is more portable and permanent, incentives for longer-term relationships between insurers and their customers, more consumer-focused service, and reduced administrative burdens on employers.[11] As the individual market becomes more representative of the overall population, insurers' perceived needs to underwrite rigorously and market selectively will lessen, making marketing more efficient and administrative loading factors less significant. Direct sellers of individual health insurance may find new opportunities to push costs even lower.

To be sure, employer coverage will retain a substantial role in a more competitive insurance marketplace. Many employers will remain the most effective agents in organizing benefit choices, bargaining for value, ensuring quality, overseeing claims administration, and pooling risks on behalf of their employees. But if full-fledged, level competition for workers' insurance business so challenges the limitations of employer coverage arrangements that employer-sponsored groups can no longer retain stable risk pools, what purpose would be served in trying to prop them up?

NOTES

1. See P.M. Danzon and S.E. Harrington, "Workers' Compensation Rate Regulation: How Price Controls Increase Costs," *Journal of Law and Economics* (April 2001): 1–36; and K.S. Abraham, "Efficiency and Fairness in Insurance Risk Classification," *Virginia Law Review* (1985): 403–451.
2. But see M. Pauly and B. Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999), 3, observing that differences in risk pooling among the large-group, small-group, and individual markets are smaller than usually thought.
3. Ibid., 88, 90–91; and K. Beauregard, *Persons Denied Private Health Insurance Due to Poor Health,* Pub. no. 92-0016 (Rockville, Md.: Agency for Healthcare Research and Quality, December 1991).
4. See E. White, "Risk Pools Aim to Cover Uninsurable, Stabilize Insurance Markets," *BNA's Health Policy Report* (27 August 2001): 1338–1341 (noting that funding for premium subsidies is the key stumbling block facing high-risk pools and suggesting that including a six-month waiting period for a preexisting health condition is more reasonable than imposing guaranteed issue insurance mandates); and C.F. Meier, "Extending Affordable Health Insurance to the Uninsurable," Heartland Policy Study no. 91 (Chicago: Heartland Institute, 27 August 1999).
5. K. Swartz, "Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?" *Inquiry* (Summer 2001): 133–145. See also S.H. Long, M.S. Marquis, and J. Rodgers, "Do People Shift Their Use of Health Services over Time to Take Advantage of Insurance?" *Journal of Health Economics* (January 1998): 112–115 (observing that recent state reforms aimed at eliminating or limiting some insurer restrictions on coverage of preexisting conditions ironically might increase patients' otherwise limited ability to adjust their treatment patterns for chronic conditions in anticipation of insurance changes).
6. See, for example, M.V. Pauly and J.S. Hoff, *Responsible Tax Credits for Health Insurance* (Washington: AEI Press, 2002); G. Arnett, ed., *Empowering Health Care Consumers through Tax Reform* (Ann Arbor: University of Michigan Press, 1999); and T. Miller, "Improving Access to Health Care without Comprehensive Health Insurance Coverage," in *Covering America: Real Remedies for the Uninsured,* vol. 2, ed. E.K. Wicks and J.A Meyer (Washington: Economic and Social Research Institute, 2002).
7. Executive Office of the President, Council of Economic Advisers, *Economic Report of the President 2002* (Washington: U.S. Government Printing Office, February 2002), 158–162; and Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2003 Revenue Proposals* (Washington: GPO, February 2002), 18–21.
8. M.V. Pauly, "Regulation of Bad Things That Almost Never Happen but Could: HIPAA and the Individual Insurance Market," *Cato Journal* (Spring/Summer 2002): 59–70; Pauly and Herring, *Pooling Health Insurance Risks,* 18; and S.E. Harrington and G.R. Niehaus, *Risk Management and Insurance* (New York: Irwin/McGraw-Hill, 1999), 460–461.
9. See M.V. Pauly, H. Kunreuther, and R. Hirth, "Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty* (March 1995): 143–156. Front-end loading, which trades off a lower present value of premiums over the period of coverage in return for long-term level premiums, generates a partial lock-in of customers and retains better risk pools. I. Hendel and A. Lizzeri, "The Role of Commitment in Dynamic Contracts: Evidence from Life Insurance," NBER Working Paper no. 7470 (Cambridge, Mass.: National Bureau of Economic Research, January 2000). John Cochrane suggests instead that the use of illness-state-contingent "severance payments" for all consumers could fund future high-risk premiums from any seller and help to maintain premiums that are constant over time. J.H. Cochrane, "Time-Consistent Health Insurance," *Journal of Political Economy* (June 1995): 445–473; see also M. Pauly, A. Nickel, and H. Kunreuther, "Guaranteed Renewability with Group Insurance," *Journal of Risk and Uncertainty* (May 1998): 211–221.
10. National Association of Health Underwriters, "Cost and Availability of Health Insurance for People with Chronic Health Conditions," 12 March 2002, www.nahu.org/NEWS/Kaiser-NAHU_Analysis.PDF (23 July 2002).
11. Regarding customized matching, we note that fewer than half (43 percent) of workers covered by employer coverage are satisfied with the overall performance of their plan. Fewer than half (48 percent) trust their employer to design a health plan that will provide the coverage they need. About the same percentage (47 percent) think that better health plans are available for the same cost. Almost four out of ten employees want their employer to contribute a fixed-dollar amount toward the premium for any health plan, even if it means finding their own plan. Watson Wyatt Worldwide, *Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management* (Washington: Watson Wyatt Worldwide, 2001).